HEALTH PROFESSIONAL'S REPORT

To the Health Professional: *Please complete every question on this Report, date and sign it personally, and deliver it to me, the guardian and/or conservator, at the address below.*

(1) Guardian and/or Conservator's Name: _____

_____

Street Address: _____
City, State, Zip: _____
Phone Number: _____

(2) Ward's Name: _____
(3) Case Number: GC_____

Diagnosis: List and describe the client's diagnosis:

Functional Impairments:

Impairment	Effects on Client's Decisions or Communication

Daily Living: Check the box next to each task the client can perform with minimal or no direction: [ ] obtaining food [ ] obtaining housing [ ] living alone [ ] taking medication [ ] paying bills [ ] driving

Medication: List all medications the client receives.

Medication	Dosage	Effects on Behavior

Prognosis: Describe your prognosis for improvement in the client's condition:

Rehabilitation: Describe your recommendation for the most appropriate rehabilitation or care plan:

Other: List any other relevant information:

Date: _____ Health Professional's Signature: _____

Printed Name: _____